



# Program Application

All information you provide is used by staff of the Woodlands Foundation, Inc., for the purpose of summer and weekend programming. All information is considered confidential. Please print in INK or type clearly. Complete the information in each section carefully and completely.

## PARTICIPANT INFORMATION

Applicant's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ Secondary: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Home Address (Street# or P.O. Box) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

County: \_\_\_\_\_ Home Phone Number: ( ) \_\_\_\_\_

Applicant's Email: \_\_\_\_\_ Applicant's Cell Phone: ( ) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Secondary Physician: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Primary Health Insurance/Carrier: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_ Policy # \_\_\_\_\_

Secondary Health Insurance/Carrier: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_ Policy # \_\_\_\_\_

**Please attach a photocopy of insurance cards.**

## PARENT/GUARDIAN INFORMATION

MOTHER	FATHER
Name: _____ (Last) (First)	Name: _____ (Last) (First)
Address: _____ (Street)	Address: _____ (Street)
Address: _____ (City, State, Zip)	Address: _____ (City, State, Zip)
Home Phone: ( ) _____	Home Phone: ( ) _____
Cell Phone: ( ) _____	Cell Phone: ( ) _____
Employer: _____	Employer: _____
Work Phone: ( ) _____	Work Phone: ( ) _____
Email: _____	Email: _____

Marital Status of Parents: \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Single Parent

\*If legal guardian, please attach documentation to establish basis of guardianship.

Check here if the participant is their own legal guardian.

Office Use Only  
 Program Year: 2010  
 Summer Camp:  
 Weekend Retreats: Jan Feb Mar Apr May  
 Jun Jul Aug Sep Oct Nov Dec  
 Database:

## **MEDICAL CONDITIONS**

Please check any medical conditions the applicant has and indicate the date of the problem and course of treatment.

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma _____                 | <input type="checkbox"/> Arthritis _____                             |
| <input type="checkbox"/> Diarrhea _____               | <input type="checkbox"/> Growth Hormone Treatment _____              |
| <input type="checkbox"/> High Blood Pressure _____    | <input type="checkbox"/> Frequent Ear Infections _____               |
| <input type="checkbox"/> Tubes in Ears _____          | <input type="checkbox"/> Urinary Tract Infections _____              |
| <input type="checkbox"/> Frequent Leg Fractures _____ | <input type="checkbox"/> Vision or Hearing Limitations _____         |
| <input type="checkbox"/> Frequent Falls _____         | <input type="checkbox"/> Seizures (see neurological history section) |

## **ALLERGIES**

	Specific Allergy	Reaction	Treatment
Foods			
Medicine			
Insects/Bees			
Latex			
Animals			
Materials			
Plants (pollen, etc.– specify)			
Other (Please Specify)			

## **IMMUNIZATION HISTORY**

	Date of Shot	Date(s) of Booster		Date of Shot	Date(s) of Booster
Measles			Tuberculin/TB		
Mumps			Diphtheria		
Rubella			Pertussis (whooping cough)		
Hepatitis B			Tetanus		
Chicken Pox			Other (specify)		

Please list childhood diseases: \_\_\_\_\_

\_\_\_\_\_

Please list and explain the applicant's hospitalizations and surgeries in the past year: (attach additional sheets if necessary) \_\_\_\_\_

\_\_\_\_\_

## **MEDICATIONS**

Name of medicine (prescription & non prescription)	Dosage	Times Taken	Form: Pills, Liquid, Chewable	Special Instructions (crush pills, take with milk, mix with food, etc.)	Purpose

Please provide any other pertinent information related to medication/administration: \_\_\_\_\_

**WEEKENDS:** Bring medication in a pre-filled pillbox or container. Growth Hormone shots are not administered during weekend retreats.

**SUMMER:** Bring medication in original containers. This cannot be emphasized enough. Do NOT pre-fill weekly pillbox. Bring enough medicine for the entire session.

## **NEUROLOGICAL HISTORY**, if applicable

Level of lesion?    Cervical (neck)    Thoracic (chest)    Lumbar (waist)    Sacral (below waist)

Does the participant have a shunt?    No    Yes   Where does the shunt start?    Left side of head    Right side of head  
 Other \_\_\_\_\_

Where does the shunt end?    Abdomen    Heart    Lung    Other \_\_\_\_\_

Does the participant have a history of seizure?    No    Yes   Type of seizure/describe seizure activity \_\_\_\_\_

How often do seizures occur? \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

## **DIETARY NEEDS**

Please explain any special diet your child needs while at camp (ex. low sodium, caffeine-free, etc.). Include food product transfusions, special handling, and pre-medications.

Please list any dietary restrictions or special diet to be followed: \_\_\_\_\_

Please list any assistance which the applicant requires at mealtimes (i.e. cutting food, portioning food): \_\_\_\_\_

Favorite Foods: \_\_\_\_\_

Least Favorite Foods: \_\_\_\_\_

Does the applicant have trouble with chewing, swallowing or gagging?    Yes    No

## **GENERAL URINARY BLADDER MANAGEMENT**

How does the applicant empty his/her bladder?

- Normal Bladder, no special program needed       Crede       Catheterization (Size of Catheter \_\_\_\_\_)
- Valsalva (sits and pushes)       Urinary Diversion       Empties onto briefs or pads
- Other \_\_\_\_\_

How often is the bladder emptied? \_\_\_\_\_

Where is the routine performed (on the toilet, from the applicant's wheelchair, lying down)? \_\_\_\_\_

In general, is the applicant wet between the times in which he/she empties his/her bladder?       Yes       No

Does the applicant consistently remember when to perform his/her bladder routine?       Yes       No

Describe the applicant's need for assistance with his/her bladder routine: \_\_\_\_\_

Does the applicant irrigate his/her bladder?       Yes       No

How often? \_\_\_\_\_

Supplies used: \_\_\_\_\_

Describe assistance needed: \_\_\_\_\_

Approximate date of most recent urinary tract infection: \_\_\_\_\_

List the applicant's most common symptoms which indicate a urinary tract infection: \_\_\_\_\_

If applicant has a urinary diversion (loop), how long does the appliance stay on? \_\_\_\_\_

Brand of ostomy supplies: \_\_\_\_\_

Size of ostomy supplies: \_\_\_\_\_

**PLEASE BE SURE TO BRING ENOUGH SUPPLIES FOR THE ENTIRE SESSION.**

**IF APPLICANT USES A NIGHT DRAINAGE BAG, BE SURE TO PACK IT.**

**No Enemas will be given during the weekend, please adjust your schedule.**

### **NOTES:**



## TRANSFERS/ADLs

Check the following activities the applicant needs assistance in doing and describe the type of assistance needed.

Self Care Item	Describe Assistance Needed
<b>TRANSFERS TO AND FROM</b>	
<input type="checkbox"/> Bed	
<input type="checkbox"/> Toilet	
<input type="checkbox"/> Shower chair	
<input type="checkbox"/> Car	
<b>ADLs</b>	
<input type="checkbox"/> Showering	
<input type="checkbox"/> Washing hair	
<input type="checkbox"/> Combing hair	
<input type="checkbox"/> Shaving	
<input type="checkbox"/> Brushing teeth	
<input type="checkbox"/> Dressing	
<input type="checkbox"/> Menstrual Needs	
<input type="checkbox"/> Organizing personal belongings	
<input type="checkbox"/> Making bed	

## EDUCATION

Name of the school where the applicant currently attends: \_\_\_\_\_

School Address: \_\_\_\_\_

Current Grade Level: \_\_\_\_\_ Teacher: \_\_\_\_\_

Type of Learning support received: \_\_\_\_\_

List applicant's favorite classes: \_\_\_\_\_

List applicant's least favorite classes: \_\_\_\_\_

Describe any current academic problem facing the applicant: \_\_\_\_\_

Would you like a WFI staff member to contact you to provide assistance in this area?  Yes  No

## **EMPLOYMENT**

Is the applicant currently working?  Yes  No

If yes, (or if applicant has in the past) where does the applicant work or volunteer? \_\_\_\_\_

Employer or Volunteer Location Address: \_\_\_\_\_

## **COMMUNITY SUPPORT AGENCIES**

Does the applicant have an open case with the **Office of Vocational Rehabilitation (OVR)**?  Yes  No

If yes, Counselor's Name: \_\_\_\_\_ District Office: \_\_\_\_\_ Phone: \_\_\_\_\_

Does the applicant have an open case with the **Office of Mental Health/Mental Retardation (MHMR)** or other third party agency?  Yes  No

If yes, Caseworker's Name: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

On behalf of the applicant, can WFI staff request program funding from these community agencies?  Yes  No

## **PSYCHO-SOCIAL ISSUES**

How does the applicant spend his/her free time? \_\_\_\_\_

Who helps the applicant solve problems and make decisions? \_\_\_\_\_

**Does the applicant have a history or show signs of the following:  
RELATING TO PEERS**

- |  |   |
|--|---|
| <input type="checkbox"/> No problem  | <input type="checkbox"/> Problem interferes with everyday functioning |
| <input type="checkbox"/> Current problem, but does not interfere with everyday functioning | <input type="checkbox"/> Severe problem that requires intervention    |

Please describe: \_\_\_\_\_

### **AGGRESSION**

- |  |   |
|--|---|
| <input type="checkbox"/> No problem  | <input type="checkbox"/> Problem interferes with everyday functioning |
| <input type="checkbox"/> Current problem, but does not interfere with everyday functioning | <input type="checkbox"/> Severe problem that requires intervention    |

Please describe problem: \_\_\_\_\_

### **AGITATION**

- |  |   |
|--|---|
| <input type="checkbox"/> No problem  | <input type="checkbox"/> Problem interferes with everyday functioning |
| <input type="checkbox"/> Current problem, but does not interfere with everyday functioning | <input type="checkbox"/> Severe problem that requires intervention    |

Please describe problem: \_\_\_\_\_

### **INAPPROPRIATE or UNUSUAL BEHAVIORS**

- |  |   |
|--|---|
| <input type="checkbox"/> No such behavior is exhibited                                     | <input type="checkbox"/> Problem interferes with everyday functioning |
| <input type="checkbox"/> Current problem, but does not interfere with everyday functioning | <input type="checkbox"/> Severe problem that requires intervention    |

Please describe behavior(s): \_\_\_\_\_

Indicate behavior management techniques that are effective: \_\_\_\_\_

Is the applicant currently receiving any form of counseling?  Yes  No If yes, for what issues? \_\_\_\_\_

Describe any other issues that staff need to be aware of in order for the applicant to fully enjoy the program. *Information will remain confidential among staff working with the applicant.* \_\_\_\_\_

## **CAMPER ACTIVITY PROFILE**

Applicants and parents should fill out this section together. This section will let program staff know the areas that are important to the applicant.

### **Check the activities that the applicant would like to participate in:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Tent Camping     | <input type="checkbox"/> Drawing                      | <input type="checkbox"/> Listening to Music          |
| <input type="checkbox"/> Singing          | <input type="checkbox"/> Working with Computers       | <input type="checkbox"/> Spirituality Programs _____ |
| <input type="checkbox"/> Basketball       | <input type="checkbox"/> Learning about Job Interests | <input type="checkbox"/> Playing Games               |
| <input type="checkbox"/> Baseball         | <input type="checkbox"/> Performing in a Play         | <input type="checkbox"/> Hanging out with Friends    |
| <input type="checkbox"/> Exploring Nature | <input type="checkbox"/> Cooking                      | <input type="checkbox"/> Working in the Camp Store   |
| <input type="checkbox"/> Taking Pictures  | <input type="checkbox"/> Making Things out of Wood    | <input type="checkbox"/> Making Crafts               |
| <input type="checkbox"/> Other(s) _____   | <input type="checkbox"/> Golf                         |  |

What level swimmer is your child?    Advanced    Intermediate    Beginner    Cannot Swim    Wants to Learn

Does your child have any certain fears (ex. Darkness, dogs, bugs, etc.)? \_\_\_\_\_

### **Check the goals that the applicant would like to pursue:**

- |   |   |
|---|---|
| <input type="checkbox"/> I would like to learn how to organize my belongings                                    | <input type="checkbox"/> I want to learn to cook (or to improve my skills)                            |
| <input type="checkbox"/> I want to find out more about different jobs   | <input type="checkbox"/> I want to learn how to look for a job  |
| <input type="checkbox"/> I want to learn how to solve friendship problems                                       | <input type="checkbox"/> I want to learn how to feel more confident                                   |
| <input type="checkbox"/> I want to learn how to speak up for myself   | <input type="checkbox"/> I want to increase my independence in my self-care routines                  |
| <input type="checkbox"/> I want to learn more about my specific disability                                      | <input type="checkbox"/> I want to learn more about my medications                                    |
| <input type="checkbox"/> I would like to learn how to keep my wheelchair and braces clean and in good condition | <input type="checkbox"/> I want to learn how to prevent skin breakdown and bowel and bladder problems |
| <input type="checkbox"/> I want to learn how to explain my disability to doctors, teachers, and friends         |   |

To the best of my knowledge all completed information given on this application is current and correct.

\_\_\_\_\_  
Signature of Parent/Guardian/Participant

\_\_\_\_\_  
Date

## **EQUAL OPPORTUNITY AGENCY**

The Woodlands Foundation, Inc. is an equal opportunity agency. Services are provided to individuals with disabilities regardless of race, creed, color, gender, national origin or marital status. Since participant safety and health are a top priority, WFI reserves the right to deny program participation to anyone whose health care or physical needs are beyond the scope of staff competency and/or specific program objectives/requirements.

The Woodlands is proud to be an American Camping Association accredited camp.